

STATE DISABILITY INSURANCE EMPLOYEE OPTIONS CHECKLIST	
Employee Name:	CBID:
Social Security Number (Only Last Four Digits):	
Immediate Supervisor Name/Phone Number:	
LEAVE OF ABSENCE	
Beginning Date:	Ending Date:
Below is a list of options that are available to you. Please make your election and return this form no later than:	
OPTION A:	
I choose to request a medical leave of absence while on SDI, and:	
<input type="checkbox"/> I DO want to use my leave credits to cover the seven (7) day SDI waiting period. (Enter which leave type you would like to use.): _____	
<input type="checkbox"/> I DO NOT want to use my leave credits to cover the seven (7) day waiting period. Other, Please Explain: _____	
OPTION B:	
<input type="checkbox"/> In addition to Option A , I want to use leave credits each month while I am receiving SDI benefits.	
Please Explain: <u>(amount/type of leave credits)</u> _____	
OPTION C:	
<input type="checkbox"/> I choose NOT to be on SDI. I wish to use leave credits to cover my absence. (Enter which leave type you would like to use.) _____	
OPTION D:	
<input type="checkbox"/> I elect to be on a leave of absence. I choose NOT to be on SDI or use leave credits.	
HEALTH INSURANCE ELECTION: Please maintain my health insurance YES/NO	
I understand that upon my return to employment, or upon separation I will be responsible for repayment of the employee's portion of the health insurance premium paid on my behalf. Initial here: _____	
Please sign and place the checklist in the enclosed envelope and return to:	
If you wish to discuss your options or need additional information, you may contact:	
Personnel Specialist Name/Phone Number:	
Employee's Signature:	Date:
For Personnel Office Use	
Leave Credits Available as of: _____	
Sick Leave: _____	Annual Leave: _____
Holiday/PH: _____	CTO: _____
Vacation: _____	Excess: _____
Other (Specify): _____	